General

Guideline Title

Clinical practice guideline: family presence during invasive procedures and resuscitation.

Bibliographic Source(s)

ENA Emergency Nursing Resources Development Committee. Clinical practice guideline: family presence during invasive procedures and resuscitation. Des Plaines (IL): Emergency Nurses Association; 2012 Dec. 8 p. [34 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: ENA Emergency Nursing Resources Development Committee. Family presence during invasive procedures and resuscitation in the emergency department. Des Plaines (IL): Emergency Nurses Association; 2009 Dec. 8 p.

Recommendations

Major Recommendations

The grades of recommendations (A–C, Not Recommended), levels of evidence (I-VII), and quality of evidence (I-IV) are defined at the end of the "Major Recommendations" field.

Description of Decision Options/Interventions and the Level of Recommendation

Please note that the references listed after each recommendation represent the evidence considered when making the recommendation. This does not mean that the evidence in each individual reference supports the recommendation.

1. There is little or no evidence to indicate that the practice of family member presence is detrimental to the patient, the family or the health care team. Level B – Moderate (O'Connell et al., 2007; Nigrovic, McQueen, & Neuman, 2007; Sacchetti, Paston, & Carraccio, 2005; Fernandez et al., 2009; Bjorshol et al., 2011)
2. There is some evidence from the international literature that acceptance of family presence may have some cultural basis. Level B – Moderate (Gunes & Zaybek, 2009; Al-Mutair, Plummer, & Copnell, 2012; Koberich et al., 2010; Leung & Chow, 2012).
3. There is evidence that health care professionals support the presence of a designated health care professional assigned to present family members to provide explanation and comfort. Level B – Moderate (Basol et al., 2009; Dingeman et al., 2007; Emergency Nurses Association [ENA], 2007; Fallis, McClement, & Pereira, 2008; Kuzin et al., 2007; Madden & Condon, 2007; McClement, Fallis, & Pereira, 2009; O'Connell et al., 2007)
4. There is some evidence that a policy regarding family member presence provides structure and support to health care professionals involved in this practice. Level B – Moderate (Basol et al., 2009; Madden & Condon, 2007; Howlett, Alexander, & Tsuchiya, 2010)

5. Family member presence during invasive procedures or resuscitation should be offered as an option to appropriate family members and should be based on written institution policy. Level B – Moderate (Basol et al. 2009; Madden & Condon, 2007; Howlett, Alexander, & Tsuchiya, 2010)

Definitions:

Levels of Recommendation for Practice

Level A Recommendations: High

- Reflects a high degree of clinical certainty
- Based on availability of high quality Level I, II and/or III evidence available using Melnyk & Fineout-Overholt grading system*
- Based on consistent and good quality evidence; has relevance and applicability to emergency nursing practice
- Is beneficial

Level B Recommendations: Moderate

- Reflects moderate clinical certainty
- Based on availability of Level III and/or Level IV and V evidence using Melnyk & Fineout-Overholt grading system*
- There are some minor flaws or inconsistencies in quality of evidence; has relevance and applicability to emergency nursing practice
- Is likely to be beneficial

Level C Recommendations: Weak

- Level V, VI and/or VII evidence available using Melnyk & Fineout-Overholt grading system*
- Based on consensus, usual practice, evidence, case series for studies of treatment or screening, anecdotal evidence, and/or opinion
- There is limited or low quality patient-oriented evidence; has relevance and applicability to emergency nursing practice
- Has limited or unknown effectiveness

Not Recommended for Practice

- No objective evidence or only anecdotal evidence available; or the supportive evidence is from poorly controlled or uncontrolled studies
- Other indications for not recommending evidence for practice may include:
    - Conflicting evidence
    - Harmfulness has been demonstrated
    - Cost or burden necessary for intervention exceeds anticipated benefit
    - Does not have relevance or applicability to emergency nursing practice
- There are certain circumstances in which the recommendations stemming from a body of evidence should not be rated as highly as the individual studies on which they are based. For example:
    - Heterogeneity of results
    - Uncertainty about effect magnitude and consequences
    - Strength of prior beliefs
    - Publication bias

Grading the Levels of Evidence*

I. Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs) or evidence-based clinical practice guidelines based on systematic reviews of RCTs
II. Evidence obtained from at least one properly designed RCT
III. Evidence obtained from well-designed controlled trials without randomization
IV. Evidence obtained from well-designed case control and cohort studies
V. Evidence from systematic reviews of descriptive and qualitative studies
VI. Evidence from a single descriptive or qualitative study
VII. Evidence from opinion of authorities and/or reports of expert committees

Grading the Quality of the Evidence

I. Acceptable Quality: No Concerns
II. Limitations in Quality: Minor flaws or inconsistencies in the evidence
III. Major Limitations in Quality: Many flaws and inconsistencies in the evidence

IV. Not Acceptable: Major flaws in the evidence

*Melnyk, B. M., & Fineout-Overholt, E. (2005). Evidence-based practice in nursing and healthcare: A guide to best practice. Philadelphia, PA: Lippincott, Williams, & Wilkins.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Conditions that require invasive procedures or resuscitation in the emergency department

Guideline Category

Management

Clinical Specialty

Emergency Medicine

Nursing

Intended Users

Advanced Practice Nurses

Emergency Medical Technicians/Paramedics

Nurses

Physicians

Guideline Objective(s)

To evaluate whether family presence has a positive or negative influence on the patient, family, and staff during invasive procedures and resuscitation

Target Population

Patients receiving emergency care and their families

Interventions and Practices Considered

Family member presence during invasive procedures and resuscitation

Major Outcomes Considered

- Patient, family and health care professional preferences

- Effect on care of patient, the family, and the healthcare staff
- Interference with care
- Quality of care

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Via a thorough literature search, all articles relevant to the topic were identified. The following databases were searched: PubMed, eTBLAST, Cochrane - British Medical Journal, Agency for Healthcare Research and Quality (AHRQ; www.ahrq.gov), and the National Guideline Clearinghouse (www.guideline.gov). Search terms included the keys words family presence or parental presence, and invasive procedures, or resuscitation and emergency. Search limitations included articles published in the English language from 2005 to 2012. Systematic, critical and comprehensive reviews included represent earlier works. Classic and seminal research on the issue, as well as non-research articles were also reviewed for historical perspective. In addition, the reference lists of articles found via literature search were scanned for pertinent references.

Articles that met the following criteria were chosen to formulate the clinical practice guideline (CPG): research studies, meta-analyses, systematic reviews, and existing guidelines relevant to the topic. Individuals studies that have been reviewed by any systematic reviews/meta-analyses were not included in the evidence table. Rather, the findings of the systematic reviews/meta-analyses were presented in the evidence table. For example, in 2007, the Emergency Nurses Association published the third edition of *Presenting the Option for Family Presence*. The review of the literature included 117 research studies. Studies in this publication were not individually referenced nor included in the Evidence Table for this CPG. Evidence identified in *Presenting the Option for Family Presence (3rd ed.)* is cited as (ENA, 2007). Other types of articles were also reviewed and provided as additional information.

Number of Source Documents

32 documents were included in the evidence tables.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Grading the Levels of Evidence*

I. Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs) or evidence-based clinical practice guidelines based on systematic reviews of RCTs
II. Evidence obtained from at least one properly designed RCT
III. Evidence obtained from well-designed controlled trials without randomization
IV. Evidence obtained from well-designed case control and cohort studies
V. Evidence from systematic reviews of descriptive and qualitative studies
VI. Evidence from a single descriptive or qualitative study

VII. Evidence from opinion of authorities and/or reports of expert committees

Grading the Quality of the Evidence

I. Acceptable Quality: No concerns
II. Limitations in Quality: Minor flaws or inconsistencies in the evidence
III. Major Limitations in Quality: Many flaws and inconsistencies in the evidence
IV. Not Acceptable: Major flaws in the evidence

*Melnyk, B. M., & Fineout-Overholt, E. (2005). Evidence-based practice in nursing and healthcare: A guide to best practice. Philadelphia, PA: Lippincott, Williams, & Wilkins.

Methods Used to Analyze the Evidence

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

The Clinical Practice Guideline authors used standardized worksheets, including Evidence-Appraisal Table Template, Critique Worksheet and Appraisal of Guidelines Research and Evaluation (AGREE) Work Sheet, to prepare tables of evidence ranking each article in terms of the level of evidence, quality of evidence, and relevance and applicability to practice. Clinical findings and levels of recommendations regarding patient management were then made by the Clinical Guidelines Committee according to the Emergency Nurses Association's classification of levels of recommendation for practice, which include: Level A High, Level B. Moderate, Level C. Weak or Not recommended for practice (see the "Rating Scheme for the Strength of the Recommendations" field).

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

This clinical practice guideline (CPG) was created based on a thorough review and critical analysis of the literature following Emergency Nurses Association (ENA)'s Guidelines for the Development of Clinical Practice Guidelines (see the "Availability of Companion Documents" field).

Conference calls with Subcommittee members and staff are held as necessary to discuss progress and facilitate the Subcommittee's work. All members of the Subcommittee independently complete an exhaustive review of all identified literature, complete a separate evidence table for each topic (if possible), and then reconvene to reach consensus. Each Subcommittee prepares a description of the topic, definition, background, significance, and evidence table. The Subcommittee identifies and assigns preliminary scores for quality and strength of evidence, and describes conclusions based on the review of the body of evidence. Each Subcommittee also serves as "second readers" for another topic; this assures an in-depth look at the literature by two Subcommittees. The entire Committee reads the articles and reviews the evidence-appraisal tables for each topic and then finalizes implications for practice and the level of recommendation.

Rating Scheme for the Strength of the Recommendations

Levels of Recommendation for Practice

Level A Recommendations: High • Reflects a high degree of clinical certainty • Based on availability of high quality Level I, II and/or III evidence available using Melnyk & Fineout-Overholt grading system* (see the "Rating Scheme for the Strength of the Evidence" field) • Based on consistent and good quality evidence; has relevance and applicability to emergency nursing practice • Is beneficial
Level B Recommendations: Moderate

- Reflects moderate clinical certainty
- Based on availability of Level III and/or Level IV and V evidence using Melnyk & Fineout-Overholt grading system* (see the "Rating Scheme for the Strength of the Evidence" field)
- There are some minor flaws or inconsistencies in quality of evidence; has relevance and applicability to emergency nursing practice
- Is likely to be beneficial

Level C Recommendations: Weak

- Level V, VI and/or VII evidence available using Melnyk & Fineout-Overholt grading system* (see the "Rating Scheme for the Strength of the Evidence" field)
- Based on consensus, usual practice, evidence, case series for studies of treatment or screening, anecdotal evidence, and/or opinion
- There is limited or low quality patient-oriented evidence; has relevance and applicability to emergency nursing practice
- Has limited or unknown effectiveness

Not Recommended for Practice

- No objective evidence or only anecdotal evidence available; or the supportive evidence is from poorly controlled or uncontrolled studies
- Other indications for not recommending evidence for practice may include:
  - Conflicting evidence
  - Harmfulness has been demonstrated
  - Cost or burden necessary for intervention exceeds anticipated benefit
  - Does not have relevance or applicability to emergency nursing practice
- There are certain circumstances in which the recommendations stemming from a body of evidence should not be rated as highly as the individual studies on which they are based. For example:
  - Heterogeneity of results
  - Uncertainty about effect magnitude and consequences
  - Strength of prior beliefs
  - Publication bias

*Melnyk, B. M., & Fineout-Overholt, E. (2005). Evidence-based practice in nursing and healthcare: A guide to best practice. Philadelphia, PA: Lippincott, Williams, & Wilkins.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Internal Peer Review

Description of Method of Guideline Validation

The Institute for Emergency Nursing Research (IENR) Advisory Council reviews the final document for overall validity and provides feedback as appropriate using the Clinical Practice Guidelines (CPGs) Evaluation Worksheet. Reviews and feedback are sent to the Subcommittee to evaluate and incorporate, as appropriate. The Emergency Nurses Association (ENA) staff creates the final products for publication with input from the Committee.

Evidence Supporting the Recommendations

References Supporting the Recommendations

Al-Mutair AS, Plummer V, Copnell B. Family presence during resuscitation: a descriptive study of nurses' attitudes from two Saudi hospitals. Nurs Crit Care. 2012 Mar-Apr;17(2):90-8. PubMed

Basol R, Ohman K, Simones J, Skillings K. Using research to determine support for a policy on family presence during resuscitation. Dimens Crit Care Nurs. 2009 Sep-Oct;28(5):237-47; quiz 248-9. PubMed

Bjorshol CA, Myklebust H, Nilsen KL, Hoff T, Bjorkli C, Illguth E, Soreide E, Sunde K. Effect of socioemotional stress on the quality of cardiopulmonary resuscitation during advanced life support in a randomized manikin study. Crit Care Med. 2011 Feb;39(2):300-4. PubMed

Dingeman RS, Mitchell EA, Meyer EC, Curley MA. Parent presence during complex invasive procedures and cardiopulmonary resuscitation: a systematic review of the literature. Pediatrics. 2007 Oct;120(4):842-54. [27 references] PubMed

Emergency Nurses Association. Presenting the option for family presence. 3rd ed. Des Plaines (IL): Emergency Nurses Association; 2007. Chapter 2: Review of the literature on family presence.

Fallis WM, McClement S, Pereira A. Family presence during resuscitation: a survey of Canadian critical care nurses' practices and perceptions. Dynamics. 2008 Fall;19(3):22-8. PubMed

Fernandez R, Compton S, Jones KA, Velilla MA. The presence of a family witness impacts physician performance during simulated medical codes. Crit Care Med. 2009 Jun;37(6):1956-60. PubMed

Gunes UY, Zaybak A. A study of Turkish critical care nurses' perspectives regarding family-witnessed resuscitation. J Clin Nurs. 2009 Oct;18(20):2907-15. PubMed

Howlett MS, Alexander GA, Tsuchiya B. Health care providers' attitudes regarding family presence during resuscitation of adults: an integrated review of the literature. Clin Nurse Spec. 2010 May-Jun;24(3):161-74. [21 references] PubMed

Koberich S, Kaltwasser A, Rothaug O, Albarran J. Family witnessed resuscitation - experience and attitudes of German intensive care nurses. Nurs Crit Care. 2010 Sep-Oct;15(5):241-50. PubMed

Kuzin JK, Yborra JG, Taylor MD, Chang AC, Altman CA, Whitney GM, Mott AR. Family-member presence during interventions in the intensive care unit: perceptions of pediatric cardiac intensive care providers. Pediatrics. 2007 Oct;120(4):e895-901. PubMed

Leung NY, Chow SK. Attitudes of healthcare staff and patients' family members towards family presence during resuscitation in adult critical care units. J Clin Nurs. 2012 Jul;21(13-14):2083-93. PubMed

Madden E, Condon C. Emergency nurses' current practices and understanding of family presence during CPR. J Emerg Nurs. 2007 Oct;33(5):433-40. PubMed

McClement SE, Fallis WM, Pereira A. Family presence during resuscitation: Canadian critical care nurses' perspectives. J Nurs Scholarsh. 2009;41(3):233-40. PubMed

Nigrovic LE, McQueen AA, Neuman MI. Lumbar puncture success rate is not influenced by family-member presence. Pediatrics. 2007 Oct;120(4):e777-82. PubMed

O'Connell KJ, Farah MM, Spandorfer P, Zorc JJ. Family presence during pediatric trauma team activation: an assessment of a structured program. Pediatrics. 2007 Sep;120(3):e565-74. PubMed

Sacchetti A, Paston C, Carraccio C. Family members do not disrupt care when present during invasive procedures. Acad Emerg Med. 2005 May;12(5):477-9. PubMed

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate inclusion of family members during invasive procedures and resuscitation in the emergency department

Potential Harms

Not stated

Qualifying Statements

Qualifying Statements

- The Emergency Nurses Association (ENA)'s Clinical Practice Guidelines (CPGs) are developed by ENA members to provide emergency nurses with evidence-based information to utilize and implement in their care of emergency patients and families. Each CPG focuses on a clinical or practice-based issue, and is the result of a review and analysis of current information believed to be reliable. As such, information and recommendations within a particular CPG reflect the current scientific and clinical knowledge at the time of publication, are only current as of their publication date, and are subject to change without notice as advances emerge.
- In addition, variations in practice, which take into account the needs of the individual patient and the resources and limitations unique to the institution, may warrant approaches, treatments and/or procedures that differ from the recommendations outlined in the CPGs. Therefore, these recommendations should not be construed as dictating an exclusive course of management, treatment or care, nor does the use of such recommendations guarantee a particular outcome. CPGs are never intended to replace a practitioner's best judgment based on the clinical circumstances of a particular patient or patient population. CPGs are published by ENA for educational and informational purposes only, and ENA does not approve or endorse any specific methods, practices, or sources of information. ENA assumes no liability for any injury and/or damage to persons or property arising out of or related to the use of or reliance on any CPG.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Quick Reference Guides/Physician Guides

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

ENA Emergency Nursing Resources Development Committee. Clinical practice guideline: family presence during invasive procedures and resuscitation. Des Plaines (IL): Emergency Nurses Association; 2012 Dec. 8 p. [34 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2009 Dec (revised 2012 Dec)

Guideline Developer(s)

Emergency Nurses Association - Professional Association

Source(s) of Funding

Emergency Nurses Association

Guideline Committee

2012 ENA Emergency Nursing Resources Development Committee

Composition of Group That Authored the Guideline

Committee Members: Lisa Wolf, PhD, RN, CEN, FAEN, Director, ENA Institute for Emergency Nursing Research; Andrew Storer, DNP, RN, ACNP, CRNP, FNP; Susan Barnason, PhD, RN, APRN-CNS, CEN, CCRN, FAAN; Carla Brim, MN, RN, CEN, CNS; Judith Halpern, MS, RN, APRN; Sherry Leviner, MSN, RN, CEN; Cathleen Lindauer, MSN, RN, CEN; Vicki C. Patrick, MS, RN, SRPN, ACNP, CEN, FAEN; Jean A. Proehl, MN, RN, CEN, CPEN, FAEN; Jennifer Williams, MSN, RN, CEN, CCRN, CNS; Judith Young Bradford, DNS, RN, FAEN

Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: ENA Emergency Nursing Resources Development Committee. Family presence during invasive procedures and resuscitation in the emergency department. Des Plaines (IL): Emergency Nurses Association; 2009 Dec. 8 p.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the Emergency Nurses Association Web site .

Availability of Companion Documents

The following are available:

- Requirements for the development of: clinical practice guidelines, clinical practice guidelines synopsis, and translation into practice (TIP) recommendations. Des Plaines (IL): Emergency Nurses Association; 2013 Dec. 40 p. Electronic copies: Available in Portable Document Format (PDF) from the Emergency Nurses Association Web site .
- Clinical practice guideline: family presence during invasive procedures and resuscitation. Synopsis. Des Plaines (IL): Emergency Nurses Association; 2012 Dec. 1 p. Electronic copies: Available in PDF from the Emergency Nurses Association Web site .
- CPG evidence table: family presence during invasive procedures and resuscitation. Des Plaines (IL): Emergency Nurses Association; 2012 Dec. 18 p. Electronic copies: Available in PDF from the Emergency Nurses Association Web site .
- CPG other resources table: family presence during invasive procedures and resuscitation. Des Plaines (IL): Emergency Nurses Association; 2012 Dec. 1 p. Electronic copies: Available in PDF from the Emergency Nurses Association Web site .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on July 14, 2011. The information was verified by the guideline developer on August 18, 2011. This NGC summary was updated by ECRI Institute on February 13, 2014. The updated information was verified by the guideline developer on April 16, 2014.

Copyright Statement

Disclaimer

NGC Disclaimer